Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ST JUDE MEDICAL JENNIFER KALO RCC 6901 PRESTON ROAD PLANO TX 75024	MFDR Tracking #: M4-08-5926-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "HCPCS describes procedure code L8680 as **'Implantable neurostimulator electrode, each'**. For this reason **L8680 is billed per each electrode.** The ANS Manufacturer's Invoice lists the quantity of leads used. Each lead contains between 4 and 8 electrode contacts (L8680) which is the number of units indicated on our HCFA 1500. The patient's physician **prescribed as medically necessary one of the four electrode lead units, totaling 4 electrodes**. Yet, Texas Mutual has only provided payment for 2 units. But, 4 electrodes were used so 4 electrodes should be reimbursed." "In addition, we are requesting full payment for procedure code L9900 billed as the **'trial stimulator received and transmitter unit'.** HCPCS described procedure code L9900 as 'Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code'. Without the Trial Stimulator Unit the trial procedure would not be complete as it is specifically programmed for the patient's pain pattern. This component is sometimes billed under procedure code L8699 which is described as 'prosthetic implant, not otherwise specified'. Whether it is reviewed as procedure code L9900 or L8699, the trial stimulator is consistently allowed in full by carriers, including Texas Mutual."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - $1,431.23

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Code L8680 Palmetto's allowance for this code is $372.49. The MAR for this code is 125% X 372.49, i.e. $465.61. Texas Mutual paid $931.22 for each date of service." "Texas Mutual believes that each contact of a single array is not due individual payment; however, each single implantable electrode array is reimbursable, therefore, two neurostimulator electrodes were used and reimbursed. For this reason Texas Mutual believes no further payment is due for the multiple contacts billed." "Code L9900 Texas Mutual will allow reimbursement for the trial stimulator/external screener system billed under HCPCS code L9900, based on same or similar procedure code L8688, neurostimulator pulse generator, dual array. Payment to the requestor of the disputed amount will follow under separate cover."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/5/2006	L8680 (X 4)	$372.49 X 125% = $465.61 X 4 units = $1,862.44. This amount minus previously paid of $931.22 = $931.22.	$931.23	$931.22
	L9900	Requestor withdrew this HCPCS on 7/7/2010	$500.00	$0.00
			Total Due:	$931.22

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on December 5, 2007.
2. On July 7, 2010, the requestor's representative, Leslee Jensen withdrew HCPCS code L9900 from this dispute; therefore, it will not be considered further in this decision.
3. Texas Labor Code §408.027, titled *PAYMENT OF HEALTH CARE PROVIDER*, effective September 1, 2007, sets out deadline for timely submitting the medical bills to the insurance carrier.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 2/28/2007

   - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 426-Reimbursed to fair and reasonable.

   Explanation of benefits dated 5/22/2007

   - CAC-W1-Workers Compensation State Fee Schedule Adjustment.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 891-The insurance company is reducing or denying payment after reconsideration.

   Explanation of benefits dated 10/11/2007

   - CAC-29-The time limit for filing has expired.
   - 731-134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.

Issues

1. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a)?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Texas Labor Code §408.027(a), titled *PAYMENT OF HEALTH CARE PROVIDER*, effective September 1, 2007, states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The requestor submitted a medical bill that indicates "Corrected claim submitted 9-5-07" that list HCPCS codes L8680 and L8699 for date of service 12/05/2006. The previous bills list the services in dispute HCPCS codes L8680 and L9900. For HCPCS codes L8680 and L8699, the respondent used denial reason codes "CAC-29" and "731". Because HCPCS code L8699 is not in dispute, the timeliness issue will not be considered further for this code. Based upon the submitted EOB dated 2/28/2007, the requestor has supported that HCPCS code L8680 was submitted timely for payment to the insurance carrier per Texas Labor Code §408.027(a).
2. Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service

is provided with any additions or exceptions in this section."

Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

- HCPCs code L8680 is described as "Implantable neurostimulator electrode, each". Per DMEPOS, HCPCS code L8680 has a fee listed of $372.49.

3. Reimbursement will be calculated as follows:

- Per DMEPOS, HCPCS code L8680 has a listed fee of $372.49. This amount multiplied by 125% = $465.61. On the disputed date of service the requestor billed for 4 units. $465.61 X 4 = $1,862.44. This amount minus previously paid of $931.22 = $931.22. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor for HCPCS code L8680. For the reasons stated above, the division finds that the requestor has established that reimbursement is due for HCPCS code L8680. As a result, the amount ordered is $931.22.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $931.22 additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $931.22 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**7/9/2010** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.